ADMINISTRATIVE RULES OF MONTANA
Rule Chapter 6.6.49
Sub-chapter: Patient-Centered Medical Homes

6.6.4901 PURPOSE

(1) The purpose of these rules is to implement the provisions of the Patient-Centered Medical Homes Act specified in Title 33, Chapter 40. These rules establish the process under which the commissioner may qualify patient-centered medical homes that meet the standards set forth in the Act and in these rules, acknowledge certain accrediting entities, and provide guidance concerning the activities of the patient-centered medical homes program.

History: 33-40-104, MCA; IMP, 33-40-104, 33-40-105, MCA; NEW, 2013 MAR p. 1686, Eff. 9/20/13.

6.6.4902 PATIENT-CENTERED MEDICAL HOME QUALIFICATION

(1) After January 1, 2014, health plans and primary care practices as defined in 33-40-103, MCA, self-funded government plans, Medicaid plans, and other health care providers offering medical services as defined in 33-22-140, MCA, may not offer or identify themselves as a patient-centered medical home or "medical home" unless the participating provider groups are qualified by the commissioner, and the health plan or other payer is utilizing healthcare providers who are qualified when offering "medical home" services to covered individuals under the plan.

(2) A primary care practice that is currently operating as a patient-centered medical home must submit an application for qualification by December 1, 2013, if the practice wishes to continue using that designation. Thereafter, any provider seeking to use the patient-centered medical home designation must apply for qualification and receive approval from the commissioner before holding itself out as a patient-centered medical home.

(3) The commissioner may provisionally qualify a patient-centered medical home for up to one year after the submission of an application, if the applicant needs additional time to obtain the necessary accreditation. The commissioner may extend the provisional status for an additional six months, if requested by the patient-centered medical home and for good cause.

(4) A primary care practice must apply for qualified patient-centered medical home qualification in a form prescribed by the commissioner.

(5) The commissioner shall maintain a list of qualified patient-centered medical homes on the agency's web site.

History: 33-40-104, MCA; IMP, 33-40-104, 33-40-105, MCA; NEW, 2013 MAR p. 1686, Eff. 9/20/13; AMD, 2014 MAR p. 3051, Eff. 12/25/14.

6.6.4903 NATIONAL ACCREDITATION

(1) A primary care practice that seeks recognition as a patient-centered medical home must obtain accreditation from a nationally recognized accrediting organization approved by the commissioner as meeting the standards of the Montana patient-centered medical home program, including any additional standards adopted in these rules.

(2) The commissioner shall approve and maintain a current list of national accrediting organizations that have demonstrated that their standards meet or exceed the required Montana standards for patient-centered medical homes.

(3) The commissioner may qualify primary care practices that have obtained the appropriate accreditation as a patient-centered medical home from an accrediting organization approved by the commissioner.

(4) Nothing in this rule prevents the commissioner from monitoring and reviewing primary care practices and health plan payers for compliance with these rules and the Patient-Centered Medical Homes Act.

History: 33-40-104, MCA; IMP, 33-40-104, 33-40-105, MCA; NEW, 2013 MAR p. 1686, Eff. 9/20/13.

6.6.4905 ESTABLISHMENT AND DUTIES OF THE PATIENT-CENTERED MEDICAL HOMES STAKEHOLDER COUNCIL

(1) The stakeholder council consists of 15 members who represent the interested parties identified in 33-40-104, MCA. The commissioner shall appoint members to serve a 12-month term beginning on October 15 of each year, beginning in 2013. Members may be reappointed.

(2) The commissioner shall consult with the stakeholder council before proposing new administrative rules, setting patient-centered medical home standards that implement, or further define, the standards set forth in 33-40-105, MCA, and establishing the process for qualifying patient-centered medical homes.

(3) The council shall advise the commissioner regarding activities relating to the promotion and coordination of the patient-centered medical home program in Montana and provide guidance concerning medical home activities.

(4) The council shall meet at least twice a year. The commissioner, or the commissioner's designee, shall provide updates regarding patient-centered medical home activities at each meeting.

(5) All stakeholder council meetings are subject to open meeting laws.

History: 33-40-104, MCA; IMP, 33-40-104, 33-40-105, MCA; NEW, 2013 MAR p. 1686, Eff. 9/20/13.

6.6.4906 TIMELINES FOR REQUIRED REPORTING

(1) Pursuant to 33-40-105, MCA, a patient-centered medical home shall report on its compliance with quality and performance measures to participating health plans and other payers and the commissioner, no later than March 31 of each year, beginning with 2015, or according to the timeline required by its contract with each payer, whichever is earlier. The commissioner may request that the report also include other information necessary to the evaluation of the Montana patient-centered medical home program.

(2) A health plan and other payers shall report to the patient-centered medical home and the commissioner regarding their compliance with the uniform set of cost and utilization measures set forth in the Act, these rules, or in the provider/payer contract, no later than March 31 of each year, beginning with 2015, or according to the timeline required by its contract with each patient-centered medical home, whichever is earlier.

(3) The commissioner shall share with the public, in the form of a summary report, de-identified, nonconfidential information contained in the reports listed in (1) and (2) at least once a year, beginning in June 2015.

History: 33-40-104, MCA; IMP, 33-40-104, 33-40-105, MCA; NEW, 2013 MAR p. 1686, Eff. 9/20/13; AMD, 2014 MAR p. 3051, Eff. 12/25/14.

6.6.4907 PATIENT-CENTERED MEDICAL HOME REPORTING—SPECIFIC QUALITY MEASURES REQUIRED

(1) A qualified or provisionally qualified patient-centered medical home (PCMH) shall report annually to the commissioner on its performance related to certain standards and health care quality measures, as prescribed by the commissioner. A PCMH health care provider that provides care to adults only, or both children and adults, shall choose at least three of the five quality measures listed in (3)(a) through (e) to report to the commissioner. A PCMH shall choose four out of five measures for the 2016 reporting year, for the report due in March 2017 and all subsequent years.

(2) A PCMH health care provider that provides care only to children, referred to as a pediatric practice, shall choose at least the child immunization performance measure in (3)(c). Reporting on depression screening in (3)(e) is optional for pediatric practices until the 2017 reporting year, for the report due in March 2018. At that time and for subsequent years, all pediatric clinics shall report on both the depression and immunization measures.

(3) The following are the quality measures to be reported as specified in (1):

(a) control of blood pressure among adults with diagnosed hypertension;

(b) screening for tobacco use and tobacco cessation intervention for adults;

(c) age appropriate immunization for children who turned age three during the reporting year;

(d) poor control of A1C levels in adults with diagnosed diabetes; and

(e) screening for clinical depression and follow-up plan for individuals age 12 and older.

(4) If a PCMH health care provider has no patient data regarding a particular quality measure, the provider may indicate, "not applicable."

(5) A PCMH health care provider may not change the reporting measures the provider chose for the 2014 reporting year until after the 2016 reporting year for the report due in March of 2017, or until otherwise instructed by the commissioner. However, a provider may report on additional measures at any time.

(6) Annually, the data on standards and quality measures are due to the commissioner on March 31 for the previous calendar year.

(7) The commissioner shall provide detailed instructions on the agency web site for reporting by qualified and provisionally qualified PCMHs on the quality measures described in (3). Data reporting requirements must be aligned with the federal Physician

Quality Reporting System (PQRS), except for childhood immunizations, and the instructions provided on the commissioner's web site.

(8) The report referenced in ARM 6.6.4906 is separate from the report required for the quality measures in (3).

(9) The commissioner may report to the public only aggregate information about quality measures.

(10) Payers who choose to participate in the Montana PCMH program, and who require reporting on quality measures in their contract with PCMH health care providers shall also use the same data reporting requirements prescribed by the commissioner, if the payer collects data on the measures described in (3).

History: 33-40-104, MCA; IMP, 33-40-104, 33-40-105, MCA; NEW, 2014 MAR p. 3045, Eff. 12/25/14; AMD, 2015 MAR p. 2250, Eff. 12/25/15.

6.6.4908 STANDARDS FOR PAYMENT METHODS

(1) A payor that currently has a medical home or patient-centered medical home component in its provider contracts or in insurance contracts issued to Montana residents shall submit a letter to the commissioner describing its method of compensating providers no later than January 1, 2015.

(2) A payor that is new to the Montana patient-centered medical home program shall submit a letter of intent describing its proposed method of compensating providers no later than 30 days before beginning participation in the program.

(3) The payor letters described in (1) and (2) must conform to the provisions of Title 33, chapter 40, MCA, applicable Administrative Rules of Montana, and any additional instructions concerning the content and detail of the letter prescribed by the commissioner.

(4) A payor may not participate in the Montana patient-centered medical home program until the commissioner approves the payor as meeting the requirements of this rule. The commissioner shall approve, disapprove, or request additional information no later than 30 days after receipt of the letter of intent.

(5) The commissioner shall maintain copies of the payor letters. After approval, these letters are available to the public, upon request. If the commissioner determines that a payor letter contains trade secret information as defined in 30-14-402(4), MCA, the commissioner shall redact or otherwise withhold such information from the public.

(6) Payment models must support enhanced primary care and promote the development of patient-centered medical home practices, according to the goals expressed in 33-40-103(4), MCA. Payment methods may include the following:

(a) payment for patient-centered medical home recognition status;

(b) reimbursement for patient-centered medical home services such as:

(i) care coordination services;

(ii) care management services;

(iii) disease management services;

(iv) population management services;

(v) behavior health specialist services; and

(vi) clinical pharmacist services.

(c) payment for improvement in quality metrics;

(d) shared savings incentives;

(e) block grants to enhance patient-centered medical home capabilities of primary care practices; and

(f) any other type of payment method that the commissioner approves as supporting the goals of the Montana patient-centered medical home program.

History: 33-40-104, MCA; IMP, 33-40-104, 33-40-105, MCA; NEW, 2014 MAR p. 3051, Eff. 12/25/14.

6.6.4909 MEASURES RELATED TO COST AND MEDICAL USAGE—UTILIZATION MEASURES

(1) A recognized patient-centered medical home payor shall report to the commissioner on the following utilization measures:

(a) emergency room visits; and

(b) hospitalization rates.

(2) A patient-centered medical home payor shall report this information for its entire member population and separately for those members that are attributed to a patient-centered medical home. If the payor does not track member attribution to a patient-centered medical home, that payor may report only for its entire member population.

(3) The commissioner shall provide detailed instructions on the agency web site regarding the required data reporting on utilization measures by patient-centered medical home payors.

(4) The first report is due March 31, 2015, and annually thereafter.

History: 33-40-104, MCA; IMP, 33-40-104, 33-40-105, MCA; NEW, 2014 MAR p. 3051, Eff. 12/25/14.